Extra No. 103

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The Gujarat Government Gazette

EXTRAORDINARY

PUBLISHED BY AUTHORITY

Vol. LXVII] WEDNESDAY, JULY 8, 2026 / ASHADHA 17, 1948

Separate paging is given to this Part in order that it may be filed as a Separate Compilation.

PART IV-A

Rules and Orders (Other than those published in Parts I, I-A, and I-L) made by the Government of Gujarat under the Central Acts

HEALTH AND FAMILY WELFARE DEPARTMENT

NOTIFICATION

Sachivalaya, Gandhinagar, 29th June, 2026

THE EPIDEMIC DISEASES ACT, 1897.

No.GY/10/HFWD/NCA/e-file/7/2025/5401/G:- WHEREAS, Leprosy (Hansen's Disease) continues to be a public health challenge in India due to its chronic infectious nature, its long incubation period, and the potential for serious nerve damage and lifelong disability if not detected early;

AND WHEREAS, Despite achieving national elimination level, pockets of high endemicity, delayed detection, Grade-II disability, and childhood cases indicate ongoing transmission and the presence of hidden cases;

AND WHEREAS, it is observed that a substantial number of cases remain unreported, especially from private healthcare providers, resulting in missed opportunities for early diagnosis, treatment initiation, prevention of disability, and interruption of transmission;

AND WHEREAS, Early detection, prompt initiation of Multi-Drug Therapy (MDT), and proper follow-up are essential to prevent deformities, reduce disease burden, block transmission, and achieve the goals of the National Leprosy Eradication Programme (NLEP) and National Strategic Plan (2023–27);

AND WHEREAS, Leprosy is associated with social stigma and discrimination, requiring timely reporting and systematic public health action for contact tracing, disability prevention, counselling, and community awareness;

AND WHEREAS, to ensure early identification, better surveillance, effective monitoring, and uniform reporting across public and private health facilities, the Government of Gujarat, in exercise of the powers conferred by sub-section (1) of section 2 of the Epidemic Diseases Act, 1897, hereby declares Leprosy as an infectious disease (i.e., notifiable disease) and makes the following regulations, namely: –

1. 1) These regulations may be called the Gujarat Leprosy Notification Regulations, 2026.

   2) They shall come into force on and from the date of their publication in the *Official Gazette*.

2. It shall be mandatory for any Government, Semi-Government, NGOs Private Hospitals, Medical Colleges, Accredited Social Health Activists (ASHAs), Registered Medical Practitioners, Laboratories, or any other Healthcare Providers to report or notify each Leprosy case (Hansen's Disease) detected or diagnosed by them to "Authorized person" i.e. Additional Director (Public Health) at State level, District Leprosy Officer /District Health Officer at District level and Municipal Health Officer of a Municipal Corporation in the State of Gujarat in Forms annexed herewith.

3. For the purpose of reporting of the case or notifying under regulation 2, a Leprosy case shall be defined as follows, namely: –

   1) "Suspected Case": A person presenting with any skin patch with loss of sensation, nerve thickening, tingling, muscle weakness, or clawing; details to be reported in Form A.

   2) "Clinically Diagnosed Case": A suspected case with clinical signs strongly suggestive of Leprosy such as hypo pigmented/erythematous anesthetic patches, nerve enlargement with sensory/motor impairment, or typical deformities; details to be reported in Form B.

   3) "Laboratory Confirmed Case": A probable case confirmed by slit-skin smear, biopsy, or other laboratory methods as per NLEP guidelines; details to be reported in Form C.

4. The purpose of reporting of the Leprosy case or notifying it under regulation 2, as a Leprosy case is as follows, namely: -

   1) To ensure early detection, treatment and prevention of disabilities,

   2) To improve case surveillance and contact tracing,

   3) To achieve the goals of Leprosy-free Gujarat in line with National Strategic Plan,

   4) To prevent social stigma and discrimination through prompt care and awareness.

5. Following shall be the Reporting Mechanism of the Leprosy case or notifying it under regulation 2, as a Leprosy case, -

   1) All public and private healthcare facilities, including laboratories, must report every Laboratory Confirmed or Clinically Diagnosed case of Leprosy to the nearest Government Health Facility within 15 Days of such diagnosis.

   2) The notification shall be made using the prescribed Nikusth-2.0 reporting format (Annexure-I).

   3) Monthly consolidated reports shall be submitted by District Leprosy Offices /District Health Offices to the State Leprosy Officer.

   4) Non-reporting or delayed reporting shall be treated as violation of the Epidemic Diseases Act, 1897.

6. All authorities shall ensure that information relating to patients is used strictly for public health purposes only and that privacy, dignity, and confidentiality of the affected persons are maintained.

7. For the purpose of enforcement of these regulations the following authorities shall be responsible, namely: -

   1) The Commissioner of Health (Urban), Government of Gujarat,

   2) The Commissioner of Health (Rural), Government of Gujarat,

   3) State Leprosy Officer, Gujarat,

   4) All District Collectors, District Development Officer, Chief District Health Officers, District Leprosy Officer, Medical Superintendents and other designated officers.

8. Testing / Treatment / Management: - The Superintendent or the Registered Medical Practitioners shall ensure that the treatment of Leprosy or such other illness is given as per standard protocols/ guidelines issued from time to time by the Central Government, State Government or World Health Organization as the case may be.

9. Penalty: Any person disobeying any regulation or order made under this regulation shall be treated as violation of the Epidemic Diseases Act, 1897.

By order and in the name of the Governor of Gujarat,

NILOFARBANU G. SIPAI,

Under Secretary to Government.

FORM A — LEPROSY NOTIFICATION (SUSPECTED CASE)

1. Patient Information

- Full Name: _____
- Age: _____ Sex: ☐ Male ☐ Female ☐ Other
- Address: _____
- Phone Number: _____
- National ID / Hospital ID: _____

2. Clinical Findings (Suspected Case)

- ☐ Hypopigmented or reddish skin patch with loss of sensation
- ☐ Nerve thickening
- ☐ Numbness/tingling
- ☐ Muscle weakness
- Other symptoms (describe): _____

3. Exposure History

- Contact with known leprosy case? ☐ Yes ☐ No
  If yes, relationship: _____
- Duration of contact: _____

4. Physical Examination

- Number of skin lesions: _____
- Nerves involved/thickened: _____
- Sensory loss: ☐ Present ☐ Absent
- Motor weakness: ☐ Present ☐ Absent

5. Provisional Classification

- ☐ Suspected PB (Paucibacillary)
- ☐ Suspected MB (Multibacillary)
- ☐ Indeterminate

6. Actions Taken

- ☐ Referred for slit-skin smear
- ☐ Referred to dermatologist
- ☐ Counselling provided

Reporting Officer Details

- Name: _____
- Designation: _____
- Facility: _____
- Signature & Date: _____

FORM B — LEPROSY NOTIFICATION (PROBABLE CASE)

Probable case = clinical signs strongly suggest leprosy, but lab confirmation pending.

1. Patient Information

- Full Name: _____
- Age: _____ Sex: ☐ Male ☐ Female ☐ Other
- Address: _____
- Phone Number: _____
- National ID / Hospital ID: _____

2. Clinical Criteria (Tick all that apply)

- ☐ Loss of sensation in one or more skin patches
- ☐ Thickened peripheral nerve(s) with sensory/motor impairment
- ☐ Compatible clinical presentation strongly suggestive of leprosy

3. Clinical Examination Findings

- Number of lesions: _____
- Type of lesions: ☐ Hypo pigmented ☐ Erythematous ☐ Dry/scaly
- Nerves involved: _____
- Sensory loss: ☐ Present Motor loss: ☐ Present

4. Differential Diagnosis Considered

- _____
- _____

5. Laboratory Status

- Slit-skin smear: ☐ Pending ☐ Inconclusive
- Skin biopsy: ☐ Pending ☐ Inconclusive

6. Probable Classification

- ☐ Probable PB
- ☐ Probable MB
- ☐ Other (specify): _____

7. Interim Management

- ☐ Referred to specialist
- ☐ Started MDT (reason: urgent clinical need)
- ☐ Awaiting confirmatory test

Reporting Officer Details

- Name: _____
- Designation: _____
- Facility: _____
- Signature & Date: _____

FORM C — LEPROSY NOTIFICATION (LABORATORY-CONFIRMED CASE)

Confirmed case = positive slit-skin smear OR biopsy showing acid-fast bacilli consistent with M. leprae.

1. Patient Information

- Full Name: _____
- Age: _____ Sex: ☐ Male ☐ Female ☐ Other
- Address: _____
- Phone Number: _____

National ID / Hospital ID: _____

2. Laboratory Confirmation

- Slit-skin smear:
  - Result: ☐ Positive ☐ Negative
  - Bacterial index (BI): _____
  - Morphological index (MI): _____
- Skin biopsy:
  - Histopathology: ☐ Consistent with leprosy
  - Type: ☐ Tuberculoid ☐ Borderline ☐ Lepromatous ☐ Indeterminate
  - Other findings: _____

3. Clinical Classification (WHO)

- ☐ Paucibacillary (PB)
- ☐ Multibacillary (MB)

4. Treatment Plan

- Start Date of MDT: _____
- MDT Regimen:
  - ☐ PB 6-month regimen
  - ☐ MB 12-month regimen
  - ☐ Modified regimen (specify): _____

5. Disability Assessment (WHO)

- Hands: Grade __
- Feet: Grade __
- Eyes: Grade __

6. Contact Tracing Done?

- ☐ Yes ☐ No
  If yes, number of contacts examined: _____

7. Final Case Status

- ☐ Newly diagnosed
- ☐ Relapse
- ☐ Transferred in

Reporting Officer Details

- Name: _____
- Designation: _____
- Facility: _____
- Signature & Date: _____

Leprosy Contact Tracing Register (LCTR)

Health Facility Name: _____Taluka/ Block: _____District: _____State: _____

Reporting Month & Year: _____

Page No.: _____

Sr. No	Date of Diagnosis of Index Case (DD/MM/YYYY)	Name of Contact	Age (Year)	Sex (M / F/ O)	Relation to Index Case	Address (Village / Town, Ward, Taluka, District)	Date of Contact Screening (DD/MM/YY)	Signs / Symptoms Present (Y/ N)	If Symptomatic, Date Diagnosed (DD/MM/YY)	

Instructions for Maintaining the Register:

1. Enter each household or neighbourhood contact of every newly diagnosed leprosy case.
2. Conduct contact screening within 1 month of diagnosis of the index case.
3. Record findings and refer any suspected cases for confirmation and treatment.
4. Update follow-up details during subsequent visits.
5. Keep this register in the facility for at least 5 years for program monitoring.

Leprosy Case Register (LCR)

Health Facility Name: _____Taluka/Block: _____

District: State: _____ Reporting Month & Year: _____Page No.: _____

Sl. No.	Name of Patient	Age (Year)	Sex (M / F/ O)	Address (Village / Town, Ward, Taluka, District	Date of Diagnosis (DD/MM/YYYY)	Type of Leprosy (MB / PB)	Disability Grade at Diagnosis (0/1/2)	Date MDT Started	MDT Type (Adult / Child , PB / MB)	Contact Screening (Y / N)

Instructions for Maintaining the Register:

1. Each newly diagnosed leprosy case must be entered as a new row.
2. Do not duplicate follow-up cases.
3. Update follow-up and disability assessment columns during every visit.
4. Enter the Nikusth-generated Case ID after online reporting.
5. Maintain this register in the facility for at least 5 years for reference and audits.

Annexure- I

Leprosy Case Notification Format

(For Mandatory Reporting of Every New Case)

1. Basic Information

Notification ID	
Date of Notification (DD/MM/YYYY)	
Name of Reporting Facility / Private Practitioner	
Type of Facility	Govt. Hospital ■ PHC/CHC ■ Private Hospital/Clinic ■ NGO ■ OTHER

2. Patient Details

Name of Patient	
Father's / Mother's / Spouse's Name	
Age (Years)	
Sex	Male ■ Female ■ Other
Mobile / Contact Number	
Full Address	

3. Clinical Details

Date of Diagnosis (DD/MM/YYYY)	
Type of Leprosy	■ PB (Paucibacillary) ■ MB (Multibacillary)
Disability Grade at Diagnosis	■ Grade-0 ■ Grade-1 ■ Grade-2
Reactions / Complications	■ Yes ■ No
History of Contact with Known Leprosy Patient	■Yes ■ No
Site of Lesions / Nerve Involvement	

4. Treatment Details

Treatment Started	■ Yes ■ No
Date of Starting MDT	
MDT Type	■ Adult PB ■ Adult MB ■ Child PB ■ Child MB
Place of Treatment (Facility Name & Address)	

5. Contact Screening

Total Household Contacts	
Number of Contacts Screened	
Number of Contacts with Skin Patch / Symptoms	
Remarks	

6. Reporting Official

Name of Reporting Person / Facility In-Charge	
Designation	
Signature / Seal	
Date	

Instructions:

1. All facilities (government and private) must notify new leprosy cases within **15 Days of diagnosis** to the District Leprosy Officer.
2. Submit this form physically or digitally (via Nikusth-2.0 portal / email / WhatsApp as per district instructions).
3. Do **NOT** include follow-up patients or previously reported cases

Medical Officer's Training Module

Annexure –II : NLEP Recording and reporting formats

U.L.F. 01

NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

PATIENT CARD

Sub center		PHC			
Block/CHC		District		State	
Registration Number			SC	ST	Others
Name			Age	Female	Male
Address (with mobile No.)					
Duration of signs/ symptom in months	……..Duration of disability, if any……..				
Mode of detection	Voluntary/by ASHA/referred by other/by contact survey/other mode				
Classification	PB	MB	New Case		Other Cases (specify)
Disability	Gr-I	Gr-II	EHF score		
Date of First Dose					

AFTER ENTERING ABOVE INFORMATION IN THE PHC TREATMENT RECORD, THIS PATIENT CARD IS TO BE TRANSFERRED TO SUB-CENTRE FOR DELIVERY OF SUBSEQUENT DOSES	Signature of Medical Officer

Date of subsequent doses:

2	3	4	5	6 (PB final)	7	8	9	10	11	12 (MB final)

Date of Discharge	Date:	RFT/otherwise deleted (specify)	

End Status	EHF score	Follow up required (after RFT) for reaction, deformity, Ulcer or eye care

THIS CARD IS TO BE MAINTAINED AT SUB-CENTRE AFTER EVERY DOSE UPDATE THE PHC TREATMENT RECORD AFTER ACHIEVEING END STATUS THE MPW SHOULD SIGN THIS CARD AND RETAIN AT SUB-CENTRE FOR FUTURE REFERENCE	Signature of Sub Centre MPW

CONTACT SURVEY IN MB/CHILD CASE	No. Examined-	Cases Detected: MB- PB-

Record of Lepra Reaction/Neuritis	
Type – I/II	Neuritis - Yes/No

Prednisolone doses issued with dates at PHC/District hospital Dates of MCR footwear if issued

Date of referral for RCS

Contact examination done on ……new cases suspected/confirmed…….

NB: this patient card is for use for the new cases as well as other cases. In urban situation this card can be used by changing sub-center/PHC/CHC with appropriate health unit area/region.

Medical Officer's Training Module

TREATMENT REGISTER FOR NEW CASES

U.L.F. 02/A

PHC _____ Block PHC/CHC _____

Districts _____ State/UTs _____ Fiscal Year _____

Reg. No.	Sub Centre	Name	Address with mobile tel. number	Age	Sex M/F	ST / SC	PB / MB	Disability Grade I / II	Date of First Dose	Date of Subsequent doses											Date of RFT
										2	3	4	5	6 (PB Final)	7	8	9	10	11	12 (MB Final)	

Medical Officer's Training Module

TREATMENT REGISTER FOR OTHER CASES

U.L.F. 02/B

PHC _____ Block PHC/CHC _____

Districts _____ State/UTs _____ Fiscal Year _____

Reg. No.	Sub Centre	Name	Address with mobile tel. number	Age	Sex M/F	ST / SC	PB / MB	Disability Grade I / II	Date of First Dose	Date of Subsequent doses											Date of RFT
										2	3	4	5	6 (PB Final)	7	8	9	10	11	12 (MB Final)	

*** - Category of case – Relapse, re-entered for treatment completion, referred and changing in classification of MB / PB**

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NLEP – LEPROSY MDT DRUG STOCK RECORD

U.L.F. 03

Use separate page for each category of MDT [MB(A) / MB(C) / PB (A) / PB (C)] – Specify category _____

(Same format to be used at PHC/District/State levels – Please specify level with name along with next highest level state)

PHC_____ Block PHC/CHC _____

Districts_____ State/UTs _____ Fiscal Year _____

Transaction Date	RECEIPT					EXPENDITURE					Balance in Hand	Stock in Patient Month
	Quantity Received	From Where	Vide Ref. No.	Batch No.	Expiry Date	Quantity Received	From Where	Vide Ref. No.	Batch No.	Expiry Date		

Medical Officer's Training Module

SENSORY ASSESSMENT

L.F. 04 (Page 1)

DATE ASSESSOR	PALM		SOLE		Comments
	RIGHT	LEFT	RIGHT	LEFT	

Key : (Put these mark/icon on the site where lasion is seen)

✓	Sensation Present within 3 cms	S	Contracture		Scar/Callus
X	Anaesthesia		Wound		Shortaning Level
∧	Clawing		Crack		

Medical Officer's Training Module

ASSESSMENT OF DISABILITY & NERVE FUNCTION

U.L.F. 04 (Page 2)

Name _____ Village _____ Date of Registration _____

S/O.W/O.D/O _____ Sub-Centre _____ Date of RFT _____

Age / Sex _____ Registration No. _____ Referred By _____

Occupation _____ MB/PB _____ Date of assessment _____

RIGHT							**LEFT**					
						←Date→						
						Vision (0.2)						
						Light closure lid gap in mm						
						Blink Present / Absent						
						Little Finger Out						
						Thumb Up						
						Wrist Extension						
						Foot up						
						Disability Grade Hands						
						Disability Grade Feet						
						Disability Grade Eyes						
On Date												
Max. (WHO) Disability Grade												
EMF Score												
Signature of Assessor												

Muscle Power
S = Strong
W = Weak
P = Paralysed

Score of Vision : Counting fingers at 6 meters
0 = Normal
1 = Blamed Vision
2 = Unable to count finger

(This Form should be filled-in at time of registration and repeated after 3 months (Once in 2 weeks in case of neuritis / reaction)

Medical Officer's Training Module

DISABILITY REGISTER

U.L.F. 05

PHC_____ Districts _____ State/UTs _____

Sl. No.	Name of the Patient	Age / Sex	Address Village / Sub-Centre / PHC with phone number	New / UT / Old Case	MB / PB	New Case (NC) / UT Case / RFT	Disability Gr. III	Site of Disability					
								Eye		Hand		Foot	
								Gr-0	Gr.II	Gr.I	Gr.II	Gr.I	Gr.II
1	2	3	4	5	6	7	8	9	10	11	12	13	14

Ulcer Simple/ Complicated	EHF Score	Neuritis	Reaction Type I / Type II	DPMR Services Provided				Refer with date				New Disability developed after starting of prednisolone			Referral Services provided / Follow up taken up / Remarks
				Steroid / Dose / Duration	Self-Care Practice	Ulcer Treatment	Other If any	RCS	Complicated Ulcer	Eye	Reaction not responding to Steroid	Eye (Gr.II)	Hand (Gr.I / Gr.II)	Foot (Gr.I / Gr.II)	
15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Medical Officer's Training Module

NLEP MONTHLY REPORTING FORM
PHC/ BLOCK PHC REPORT

U.L.F. 06 (Page 1)

PHC _____ Block _____

District _____ State _____

Reporting Month _____ Year _____

1	No. of balance cases at the beginning of the month			1.1 New Cases		1.2 Other Cases
		PB				
		MB				
		Total				
2	No. of new Leprosy Cases detected in the reporting month			During Reporting Month		
				PB	MB	TOTAL
		Adult				
		Child				
		Total				
	Among new cases – number from other states	Total				
3	Among new leprosy cases detected during the reporting month, number of	Female				
		Disability	Grade – I			
			Grade – II			
		SC				
		ST				
4	Number of New Leprosy Cases deleted during the month	RFT				
		Otherwise deleted				
		Total				
5	Number of New Leprosy Cases under treatment at the end of the month (1.1+2-4)					
6	Number of "Other Cases" recorded and put under treatment	(I) Relapse				
		(II) Reentered for treatment				
		(III) Referred				
		(IV) Reclassified				
		Total				
7	No. of other cases deleted from treatment	RFT				
		Otherwise deleted				
		Total				
8	No. of other cases / under treatment at the end of reporting month (1.2+6-7)					
9	Total number of cases under treatment at the end of month	New + Others (5+8)				
10	Leprosy Drug Stock at the end of the reporting month (if required use extra sheets)					

Blister Pack	Quantity	Expiry Date	Total Stock	No. of patients under treatment (New & Others)	Patient Months BCP
MB (A)					
MB (C)					
PB (A)					
PB (C)					

NB. Please calculate patient-t Month Blister packs for MB (A), MB (C),PB (A), PB (C) Quantity in the month of March, June, September and December and include the same in that respective Monthly Report.

REMARKS (If any):-

Signature of Medical Officer

Medical Officer's Training Module

NLEP MONTHLY REPORTING FORM PHC/ BLOCK PHC REPORT

U.L.F. 06 (Page 2)

S. No.	Indicators	During Reporting Month		
		PB	MB	Total
1	No. of New Leprosy cases recorded			
2	No. of reaction cases managed at PHC			
3	No. of reaction cases referred to Dist. Hospital / Other Inst.			
4	No. of relapse cases suspected and referred			
5	No. of relapse cases confirmed at district hospital			
6	No. of cases developed new disability after MDT			
7	No. of patient provided with footwear			
8	No. of patient provided with self care kit			
9	No. of patient referred for RCS			
10	No. of new cases confirmed at PHC out of referred by ASHA			
11	No. of case completed treatment through ASHA			
12	No. of ASHA paid incentives			
13	No. of Contacts examined			
14	No. of cases detected amongst contacts			
15	No. of cases voluntarily reported, out of new cases recorded (Sl.No.1)			

Signature of Medical Officer.

Signature Not Verified
Signed by : BHOLUSINGH G THAKUR
Senior Manager
Government Central Press,
Gandhinagar
Date : 2026.07.25 15:32:40 IST